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GUY P. JONES
EDITOR

Committees on Public Health in Chambers of Commerce

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There are many good reasons why there should be an active committee on public health in the working organization of all chambers of commerce. The day is past when business may ignore the relation of the public health to social welfare and economic success. Matters concerning garbage disposal, sewer systems and outlets, insect and parasite menace, communicable disease and epidemics, food supply and contamination, overcrowding in places of residence and congregation, etc., should come before such a committee if for no other reason than analysis and presentation to the public.

The first and only interest of a committee on public health should be the promotion of the welfare of all the people. It must not spread propaganda nor be active in the interests of any group of practitioners. Therefore, such a committee should represent all business, professional and industrial groups for *all* are, more or less, affected by the health of the community.

One of the accepted methods of stopping losses in business is to prevent sickness and accidents. This not only refers to industry but to all social groups, generally. Sick men and women are nonproducers and a burden to others. Occupational diseases, for the most part, and most accidents, are preventable.

There are, of course, many phases of food preparation and source of supply; control of contagious diseases, and prevention of industrial hazard, both

health and accident. Favorable results in legislation and supervision may be had if business can be made to see that it pays to give more attention to public health matters than is being given at present.

The following suggestions are proposed as activities of public health committees of chambers of commerce:

1. Cooperate with city and county State health officials.
2. Strive to coordinate the health activities and services of the city and county, the public schools and other official, quasi-official and community chest agencies.
3. Participate in the National Inter-Chamber Health Conservation Contest.
4. Participate in National programs to improve public health.
5. Study and analyze proposed health laws for city, county, State and Nation, and report to chamber of commerce boards of directors with recommendations.
6. Subscribe to membership in the American Public Health Association.
7. Study and analyze the sources of financial support for local public health service.
8. Plan a program and objective for future public health work.
9. Study and analyze present methods of garbage and sewage disposal to anticipate the needs of the growing community.

10. Encourage preemployment physical examinations by industrial commercial and other establishments.

11. Study, analyze and report on present and proposed laws that may have a bearing on the health of the community.

12. Investigate and report on the extent of enforcement of present health laws in the community.

13. Study and analyze the present health laws of the community (city, county, etc.), to segregate the obsolete from the modern.

14. Conduct an educational campaign to inspire manufacturers to beautify the grounds surrounding their plants and thus reduce fire risk, disease, compel disposal of waste and junk and increase the efficiency and health of the worker.

15. To obtain educational publicity in local newspapers to acquaint the reader with the principles of public health.

CHILDHOOD TUBERCULOSIS, ROENTGENOLOGICALLY CONSIDERED

(Continued from last issue)

Let us next consider the serious lesions, frank pulmonary infiltrations. These are the lesions that cause concern. We have never been interested in any complicated classification of tuberculosis, nor have we endeavored to follow some of the more complex ways of reporting. When we see such reports it always seems that the specialist is trying to confuse the general practitioner. We do not know what people are talking about when they speak of "epi-tuberculosis." Pathologists tell us that tuberculosis is tuberculosis whenever and wherever it is found, differing slightly, depending on the age of the patient, stage of the disease, individual reaction and dosage and virulency of the bacilli.

Pulmonary infiltrations in children may be classified as minimal, moderately advanced and far advanced. However, as most lesions in children are pneumonic in type, they are difficult to classify or predicate.

Destructive and nondestructive lesions are good terms to use. Cases showing progressive lesions and cavities are to be considered destructive types, and cases showing no cavities and lesions that are regressive are considered nondestructive types. Cavities seen in destructive types of lesions are usually the punched-out variety.

We found 242 cases that we chose to classify as minimal; 46 moderately advanced; 87 far advanced, and 8 miliary. We shall now discuss these as a whole.

Confluent or consolidated areas of infiltration may be found anywhere in the lungs and may be any size, varying from the smallest focal spot that can be recognized roentgenologically, to extensive lobar consolidation in both lungs. We have found the nodular type of lesions in young children relatively infrequent. These are more frequently found in the 'teen age, and the lymph nodes are usually not involved. The persistency of pneumonic lesions helps to differentiate them from broncho-pneumonia. When we see a lesion of this type we immediately suggest to the clinician that the patient return in a month. At the end of this time, if the lesion persists we may assume that it is tuberculous. If it disappears, it was probably nontuberculous, although this is not necessarily true. We have no way of proving that it was tuberculous except probably by stomach washings, sputum and stool examinations. A positive Mantoux in an infant would be of some consequence.

We classified 46 cases as broncho-pneumonia, which are not included in these series. We all agree that most childhood lesions tend to heal, and treatment, in many cases, requires only general hygiene in the prevention of further infection.

This has been my experience with minimal lesions in children. When a child is taken out of his infective environment, the lesions tend to diminish and most tend to disappear within a year.

Of course the patients who have more advanced lesions require careful consideration, as most of the cases are due to overwhelming infection or numerous reinfections. The more I study this question the more I am convinced that many times the whole process is more a matter of amount of infection than anything else. Miliary tuberculosis is a typical example.

Assuming that the adult type of tuberculosis is the result of reinfection, the subject may not be so complicated. For example a child's mother has open pulmonary tuberculosis. She infects her child for the first time, and he gets a primary infection (probably minimal in extent). The next week or month she infects him again. Now what is it? It must be secondary or reinfection, and perhaps he has become moderately advanced. She again infects him, and he becomes far advanced. He now has, in the course of a few months, a combination of infections, viz: primary, secondary, tertiary and so on, which can not be differentiated as lymph node involvement would be of no consequence. Overwhelming infection accounts for most of our serious cases. Nevertheless, when we see a slight lesion persisting or spreading we must consider bronchogenic spread to account for such a condi-

tion, or the patient's lowered resistance or high virulence of the bacilli.

Most of the far advanced and miliary cases that we have studied have given a history of continued contact to an open case of pulmonary tuberculosis, and such cases as these might be spoken of as "forgotten children."

Many times a physician causes the mother a great deal of worry because her child has a slight temperature, a positive Mantoux test, rales in the chest and whose Roentenogram shows slight calcification. We think that there should be more than this present in the chest to cause alarm.

We do maintain, however, that so long as a good Roentenogram shows definite persistent infiltration in any portion of a child's lungs (which has no connection with the bronchial tree), that is not completely in the form of calcification or fibrosis (although fibrosis is uncommon in children), the lesion should be considered tuberculous and, therefore, dangerous. Furthermore, it is safer to treat a case on the basis of pathological activity (viz: anatomical lesion shown on Roentgen examination), than to wait until clinical activity is manifested.

It used to be considered a mark of poor training to rely on X-ray findings, but we find the clinical master of today frankly unwilling to give a final opinion until he sees the Roentgen evidence. There should be no arguments concerning X-ray examination versus physical examination. Roentgen examination should be considered an integral part of the general examination of the chest. A good clinician soon learns to know how much dependence can be placed on any given examination. For example, if the laboratory should report the finding of one or two acidfast bacilli in the sputum, he is not going to make a diagnosis of tuberculosis until several sputum examinations have been made as well as cultures, guinea pig inoculations, X-ray examinations, et cetera.

The same applies to indefinite X-ray findings. Serial films should be used often. Why does not the clinician and the internist make repeated examinations and other tests?

I know of no better way of studying tuberculous lesions than by serial X-ray films.

CONCLUSIONS

1. The principle value of the X-ray examination is to rule out frank pulmonary infiltrations, which, after all, is the big problem.

2. I believe writers have cited exceptions in showing calcified lesions, which later developed into tuberculous disease.

3. If the contact to infection is removed, do patients who have calcified lung or tracheobronchial lesions, or who have a positive Mantoux test, have a better chance of escaping tuberculosis later than the patient with no calcified lesions, or who reacts negatively to the Mantoux test?

4. Should we pay more attention to nonreactors than we have in the past?

5. We are ignoring too many so-called benign fibroid cases in adults. A great many of these cases are not healed and will, therefore, infect our children.

6. It seems to be well established that the virulent tubercle bacillus and the B.C.G. vaccine confer a relative immunity. However, getting rid of the source of infection will probably be one of the big factors for years to come.

THE 1933 HEALTH CONSERVATION CONTEST

Enrollment in the 1933 health conservation contest conducted under the auspices of the United States Chamber of Commerce and the American Public Health Association is now under way. The following cities in California have already enrolled in this contest: Los Angeles, San Francisco, Pasadena, Palo Alto, Riverside and Redlands.

The following California cities are eligible for enrollment in the contest: Alhambra, Altadena, Anaheim, Atascadero, Bakersfield, Balboa, Berkeley, Brawley, Brentwood, Burlingame, Calexico, Chula Vista, Colusa, Compton, Concord, Crescent City, El Centro, El Segundo, Eureka, Exeter, Fresno, Gilroy, Glendora, Hayward, Hollister, Holtville, Huntington Beach, Hynes, Imperial, Lodi, Long Beach, Los Gatos, Madera, Manteca, Martinez, Modesto, Monrovia, Montebello, Monterey, Morro Bay, National City, Oakdale, Oakland, Ontario, Palm City, Paso Robles, Petaluma, Pittsburg, Pomona, Richmond, Sacramento, St. Helena, Salinas, San Diego, San Fernando, San Jose, San Luis Obispo, Santa Ana, Santa Barbara, Santa Cruz, Santa Monica, Santa Paula, Santa Rosa, Sebastopol, Sierra Madre, Sonoma, Torrance, Ventura, Visalia, Watsonville and Whittier.

DOCTOR WYNNS RETURNS

Dr. H. L. Wynns, Chief of the Bureau of Epidemiology of the California State Department of Public Health, has returned to his duties after a year of advanced study in eastern cities. Dr. Wynns has devoted his leave to intensive work in the study of the prevention and control of communicable diseases and public health administration.

MORBIDITY***Diphtheria**

29 cases of diphtheria have been reported, as follows: Fresno County 2, Los Angeles County 3, Glendale 2, Los Angeles 12, Orange County 1, Riverside 2, Sacramento County 1, San Diego 3, Oxnard 1, Santa Paula 2.

Chickenpox

151 cases of chickenpox have been reported. Those communities reporting ten or more cases are as follows: Berkeley 14, Oakland 10, Los Angeles 33, Pasadena 10, San Diego 14, San Francisco 10.

Measles

343 cases of measles have been reported. Those communities reporting ten or more cases are as follows: Los Angeles County 44, Long Beach 13, Los Angeles 93, Pasadena 14, Santa Monica 11, Orange County 12, Santa Ana 18, San Diego 11, Ventura County 10.

Scarlet Fever

88 cases of scarlet fever have been reported. Those communities reporting ten or more cases are as follows: Los Angeles County 10, Los Angeles 25.

Whooping Cough

218 cases of whooping cough have been reported. Those communities reporting ten or more cases are as follows: Berkeley 20, Oakland 11, Los Angeles County 31, Los Angeles 38, San Joaquin County 12.

Smallpox

8 cases of smallpox have been reported, as follows: Bakersfield 1, Los Angeles 3, Santa Monica 1, Santa Clara County 2, Ventura County 1.

Typhoid Fever

6 cases of typhoid fever have been reported, as follows: Colusa 1, Compton 2, Los Angeles 1, San Joaquin County 1, Tulare County 1.

Meningitis (Epidemic)

2 cases of epidemic meningitis have been reported, as follows: Los Angeles 1, San Francisco 1.

Poliomyelitis

3 cases of poliomyelitis have been reported, as follows: Los Angeles 2, San Diego 1.

* From reports received on July 10th and 11th for week ending July 8th.

Food Poisoning

One case of food poisoning from Burbank has been reported.

Undulant Fever

5 cases of undulant fever have been reported, as follows: Los Angeles County 1, La Verne 1, Los Angeles 1, Pasadena 1, Pomona 1.

QUARANTINE PLACED ON MUSSELS

Under date of June 22, 1933, Dr. Giles S. Porter, Director of the State Department of Public Health, placed a quarantine upon mussels in certain sections of the coast of California. It became necessary to establish this quarantine because of the highly toxic condition of mussels, as revealed through laboratory tests. Health officers throughout the State have been advised of this quarantine and have been instructed to enforce it rigidly.

It is advisable to issue warnings to individuals who may be members of beach parties within the restricted areas, since it is customary for large numbers of people to visit the mussel-growing areas on Saturdays and Sundays of each week during the summer season. It is particularly necessary that such individuals be advised of the dangers that may lie in eating mussels gathered at this season of the year. It is possible that cooking these shellfish in water, to which a tablespoonful of bicarbonate of soda has been added for each quart, will destroy most of the poison. Simply cooking shellfish in plain water will not destroy the poison.

Following is the text of the quarantine order:

Laboratory examinations have shown that mussels from certain sections along the coast of California are *now* poisonous. Therefore, a quarantine of all mussels is hereby established. This quarantine covers the coast area from Monterey County to the Klamath River in Del Norte County, with the exception of the bay of San Francisco.

Under the provisions of this quarantine order the sale or offering for sale of mussels gathered from the specified areas for the period June 22d to September 30th, 1933, is prohibited.